	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155596	B. WIN	G		08/02/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VILLIAMS ST		
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION		ANGOL	_A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification,	K00	000	This Plan of Correction is the		
	State Licensure				center's		
		c-thru Survey were			credible allegation of compliance.		
		he Indiana State			Propagation and for execution	of	
	Department of				Preparation and /or execution of this		
	-				plan of correction does not		
	accordance with 42 CFR 483.70(a). Survey Date: 08/02/12				constitute admission or		
					agreement by the provider of the truth of the fact	•	
		C/ C_/			al-	5	
	Facility Number: 000474 Provider Number: 155596 AIM Number: 100290510				leged or conclusions set forth	in	
					the		
					statement of deficienceis. The	;	
	All Nulliber.	100290310			plan of correction is prepared and/or executed		
	Curvovor: Amy	Vallay Life Safety			solely because it is required by	/	
		Kelley, Life Safety			the		
	Code Specialist				provisions of federal and state		
	At this Life Safe	ety Code survey,			law.		
	Lakeland Skille						
		was found not in					
	-	h Requirements for					
	Participation in						
	Medicare/Medi						
	Subpart 483.70	•					
		he 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
		410 IAC 16.2. The					
	_	g consisting of the					
	· ·	and the service hall					
		vith Chapter 19,					
	Existing Health	Care Occupancies.					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	 _	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETI	
		155596	B. WIN			08/02/20	12
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
IVKELVI	ND SKII I ED NI IDS	SING AND REHABILITATION			VILLIAMS ST A, IN 46703		
				l			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE
	This one story	facility was					
	_ ·	be of Type V (111)					
	construction and was fully						
		he facility has a fire					
	alarm system v	•					
	I -	e corridors and					
		the corridors. The					
	· ·	s on the 300 hall					
	and 400 hall had hard wired smoke detectors. The resident						
	rooms on the 200 hall had battery operated smoke detectors. The						
	facility has a capacity of 75 and						
	· ·	of 74 at the time of					
	this survey.	or rate the time of					
	ins survey.						
	The facility was	s found in					
	compliance wit						
	-	ikler coverage and					
	smoke detecto						
		. corolago					
	All areas where	e the residents have					
	customary acco	ess were					
	sprinklered. T	he facility had a					
	detached shed	providing facility					
	services includ	ing maintenance					
	supplies that w	vas not sprinklered.					
		Robert Booher, Life Safety					
	Code Specialist-Me	edical Surveyor on 08/07/12.					
	The facility was	s found not in					
	The facility was						
	compliance wit						
	aforementione	u regulatory					

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Event ID: 2SVX21

Facility ID: 000474

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND PLAIN	OF CORRECTION	155596	A. BUILDING	01	08/02/2012
		10000	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/02/2012
NAME OF P	PROVIDER OR SUPPLIER			WILLIAMS ST	
	ND SKILLED NURS	ING AND REHABILITATION		LA, IN 46703	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1110		s evidenced by the			, , , , , , , , , , , , , , , , , , ,
	following:	is evidenced by the			
	Tollowing.				
A Life Safety Code Recertification,					
	•				
	State Licensure	•			
		k-thru Survey were			
	<u> </u>	he Indiana State			
	Department of				
	accordance wit	h 42 CFR 483.70(a).			
	Survey Date: 0	8/02/12			
		-,, -			
	Facility Numbe	r: 000474			
	Provider Numb	er: 155596			
	AIM Number:	100290510			
	Surveyor: Amy	Kelley, Life Safety			
	Code Specialist	:			
		ety Code survey,			
	Lakeland Skille				
		was found not in			
	-	h Requirements for			
	Participation in				
	Medicare/Medi	,			
	•	O(a), Life Safety			
		he 2000 edition of			
	the National Fi				
		FPA) 101, Life Safety			
	Code (LSC) and	l 410 IAC 16.2. The			

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	NSTRUCTION 01	(X3) DATE SUF COMPLETI		
ANDILAN	or correction	155596	A. BUIL			08/02/20	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				VILLIAMS ST		
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION		ANGOL	A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re C	OMPLETION DATE
TAG		ng consisting of the		IAG	,		DATE
	_	-					
	200, 300 halls and the service hall was surveyed with Chapter 19,						
	-	Care Occupancies.					
	J 3	, , , , , , , , , , , , , , , , , , ,					
	This one story	facility was					
		be of Type V (111)					
	construction a	•					
	· ·	he facility has a fire					
	alarm system with smoke						
	detection in the corridors and						
	<u> </u>	the corridors. The s on the 300 hall					
	and 400 hall ha						
		rs. The resident					
		200 hall had battery					
		e detectors. The					
	· ·	apacity of 75 and					
	=	f 74 at the time of					
	this survey.						
	The facility was						
	compliance wit						
		kler coverage and					
	smoke detecto	r coverage.					
	All areas where	the residents have					
	customary acce	ess were					
	l •	he facility had a					
		providing facility					
		ing maintenance					
	supplies that w	as not sprinklered.					

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Event ID: 2SVX21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155596	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 08/02	LETED
	PROVIDER OR SUPPLIER ND SKILLED NURSING AND REHABILITATION	500 N V	ADDRESS, CITY, STATE, ZIP WILLIAMS ST .A, IN 46703	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/07/12.				
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

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Event ID: 2SVX21

Facility ID: 000474

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155596	B. WIN	G		08/02/	2012
	ROVIDER OR SUPPLIER	ING AND REHABILITATION		500 N V	ADDRESS, CITY, STATE, ZIP CODE VILLIAMS ST A, IN 46703		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	NFPA 101 LIFE SAFETY CO Any door in an execution enclosure, horizon hazardous area et by devices arrangall such doors by facility upon activation a) the required mobility upon activation of the automatic sinstalled. 19.2.2 Based on observing the ensure 1 of 5 h door sets was leaded evice which we close automatic activation of the This deficient putwo of five smooth findings included assed on observing the 300 hall nurrelease upon active and the source of the s	DDE STANDARD (it passageway, stairway) Intal exit, smoke barrier or enclosure is held open only ged to automatically close zone or throughout the ation of: anual fire alarm system; Interest designed to detect arough the opening or a letection system; and sprinkler system, if 2.2.6, 7.2.1.8.2 Invation and facility failed to norizontal exit fire sheld open only by a rould allow it to cally upon the fire alarm system. Dractice could affect one of the compartments. Ide: Invation with the supervisor on the fire the 400 hall from the station of the fire the fire the 400 hall from the station of the fire the	Koo	TAG	K021 Upon failure of the hold open magnetic 9-1-12 devices the fire doors entering 400 hal from 300 hall, Symplex, the fire system vendor was called and asked to fix this issue. It will be corrected on 8-20-12These do will be tested one time per were to make sure the system is working properly and will be tested each time Symplex is working on any part of the system, prior to them exiting the premise. If no issues are presented in three months the audit will decrease to testing the doors one time per month durithe monthly fire drill. See Attachment A, Fire Door Audi Sheet. The audit sheet will be turned into the Safety Committed on a monthly basis for review. The Safety Committee oversee the system is the audits to the Quality Assurance Committee oversee.	s on I e le pors ek ne ne ng t	
alarm. This was acknowledged by							

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Event ID: 2SVX21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	01	COMPLETED
		155596	B. WING			08/02/2012
NAME OF P	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP CODE	
IVKEIV	ND SKII I ED NI IDS	SING AND REHABILITATION			VILLIAMS ST A, IN 46703	
					A, IN 40703	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	р	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	the Maintenan	ce Supervisor at the			by the Administrator.	
	time of observ	•				
	time or object vi	ution.				
	3.1-19(b)					
	3.1 13(5)					
	Based on obse	rvation and				
		facility failed to				
		norizontal exit fire				
		held open only by a				
		ould allow it to				
	close automati					
		ne fire alarm system.				
		practice could affect				
	1	oke compartments.				
	Findings includ	de:				
	Based on obse	rvation with the				
	Maintenance S	upervisor on				
		:40 p.m., the hold				
	open magnetic	devices on the fire				
	doors entering	the 400 hall from				
	the 300 hall nu	urses station did not				
	•	ctivation of the fire				
		as acknowledged by				
		ce Supervisor at the				
	time of observ	ation.				
	3.1-19(b)					

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Event ID: 2SVX21

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	onstruction 01	CON	TE SURVEY MPLETED
		155596	B. WING		08/	02/2012
	PROVIDER OR SUPPLIEF	SING AND REHABILITATION	500 N V	ADDRESS, CITY, STATE, ZIP VILLIAMS ST .A, IN 46703	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	ensure 1 of 5 h door sets was device which w close automati activation of th This deficient p two of five smo Findings includ Based on obse Maintenance S 08/02/12 at 2 open magnetic doors entering the 300 hall nu release upon a alarm. This wa the Maintenanc time of observ 3.1–19(b)	facility failed to norizontal exit fire held open only by a yould allow it to cally upon ne fire alarm system. practice could affect oke compartments. de: rvation with the upervisor on :40 p.m., the hold devices on the fire the 400 hall from urses station did not activation of the fire as acknowledged by ce Supervisor at the ation.				
	Based on obse interview, the	rvation and facility failed to				

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155596	B. WIN			08/02/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
ΙΔΚΕΙΔΝ	ND SKILLED NITIBS	SING AND REHABILITATION			VILLIAMS ST A, IN 46703		
				<u> </u>			aus)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	ensure 1 of 5 h	norizontal exit fire					
		held open only by a					
	device which would allow it to						
	close automati						
		ne fire alarm system.					
		practice could affect					
	· ·	oke compartments.					
		•					
	Findings includ	de:					
	_						
	Based on obse	rvation with the					
	Maintenance S	upervisor on					
	08/02/12 at 2	:40 p.m., the hold					
	open magnetic	devices on the fire					
	doors entering	the 400 hall from					
	the 300 hall nu	ırses station did not					
	release upon a	ctivation of the fire					
	alarm. This wa	as acknowledged by					
	the Maintenan	ce Supervisor at the					
	time of observ	ation.					
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155596	B. WIN	G		08/02/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE VILLIAMS ST		
		ING AND REHABILITATION			A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
K0044	NFPA 101	ESC IDENTIF TING INFORMATION)	+	IAG			DATE
SS=E	LIFE SAFETY CO Horizontal exits, it with 7.2.4. 19.2	f used, are in accordance 2.2.5					
	Based on obser	rvation and	K00)44	K 044 Upon the failure of the fi		09/01/2012
	interview, the f	acility failed to			door set 9-1-12 entering 400 I from 300 Hall, to latch into the	⊣all	
	ensure 1 of 5 f	ire door sets was			frame, the superintend- ant for	•	
	arranged to au	tomatically close			the building project immediatel		
	and latch. LSC	19.2.2.5 requires			ad- justed the door so that it		
	horizontal exit	s to be in			would close properly and latch		
	accordance wit	h 7.2.4 and	into the frame. This was completed on 8- 2-12. In order to			to	
	7.2.4.3.8 requires fire doors to be self closing or automatic closing				make sure this door set is		
					properly working, the door set		
	in accordance v	with 7.2.1.8. In			be tested weekly. See Attach-		
	addition NFPA	80, Standard for			ment A, Fire Door Audit. If the weekly test does not produce any		
	Fire Doors and				issues in three months, then the		
	2–1.4.1 require				weekly tests will decrease to o		
	-	nall be adjusted to			time monthly during the month		
		resistance of the			fire drill. The weekly audit shee	et	
	latch mechanis				will be reviewed by the Safety Committee on a monthly basis	-	
		eved on each door			The Safety Committee will sub		
	_	s deficient practice			the audits To the Quality		
	affects two of f				Assurance Com- mittee overse	een	
					by the Adminis- trator.		
	compartments.	•					
	Findings includ	le:					
	Based on an ob	servation with the					
	Maintenance Su						
		:20 p.m., the fire					
		ng the 400 hall					
		ng the 400 han Iall nurses station					
		ian nurses station ito the frame when					
	manually tester	d. The left hand					

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Event ID: 2SVX21

Facility ID: 000474

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/02/2012
	PROVIDER OR SUPPLIEF	SING AND REHABILITATION	500 N \	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST _A, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and latching. acknowledged Supervisor at to observation. 3.1–19(b) Based on obseinterview, the ensure 1 of 5 farranged to au and latch. LSC horizontal exitt accordance with 7.2.4.3.8 requiself closing or in accordance addition NFPA Fire Doors and 2–1.4.1 requiremechanisms slovercome fire latch mechanisms slovercome fire latch mechanisms ach	door from closing This was by the Maintenance he time of rvation and facility failed to fire door sets was tomatically close 19.2.2.5 requires s to be in th 7.2.4 and fires fire doors to be automatic closing with 7.2.1.8. In 80, Standard for Windows at the sall closing mall be adjusted to resistance of the times of positive fieved on each door s deficient practice five smoke .			
	i mumys metuc	ıc.			

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		LDING	NSTRUCTION 01		SURVEY LETED 2/2012	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION	500 N W	DDRESS, CITY, STATE, ZIP CODE /ILLIAMS ST A, IN 46703	2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Maintenance Some National Nati	:20 p.m., the fire ng the 400 hall nall nurses station nto the frame when d. The left hand n the flooring door from closing This was by the Maintenance				
	ensure 1 of 5 f arranged to au and latch. LSC horizontal exit accordance wit 7.2.4.3.8 requi self closing or in accordance addition NFPA Fire Doors and 2-1.4.1 require	facility failed to fire door sets was tomatically close 19.2.2.5 requires to be in the 7.2.4 and fires fire doors to be automatic closing with 7.2.1.8. In 80, Standard for Windows at				

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPLE	ETED
		155596	B. WIN			08/02/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	· ·		500 N V	VILLIAMS ST		
		SING AND REHABILITATION			A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		resistance of the					
	latch mechanis	sm so positive					
	latching is ach	ieved on each door					
	operation. Thi	is deficient practice					
	affects two of	five smoke					
	compartments						
	Findings include:						
	i mamga melat	<i>.</i>					
	Based on an observation with the						
	Maintenance Supervisor on						
	08/02/12 at 1	:20 p.m., the fire					
	door set enteri	ing the 400 hall					
		nall nurses station					
		nto the frame when					
		d. The left hand					
	door rubbed o	-					
	·	door from closing					
	and latching.						
		by the Maintenance					
	Supervisor at t	he time of					
	observation.						
	3.1-19(b)						
	Based on obse	ryation and					
		facility failed to					
		fire door sets was					
		itomatically close					
	and latch. LSC	19.2.2.5 requires					
	horizontal exit	s to be in					

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Facility ID: 000474

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NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects two of five smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor on 08/02/12 at 1:20 p.m., the fire door set entering the 400 hall from the 300 hall nurses station did not latch into the frame when manually tested. The left hand door rubbed on the flooring preventing the door from closing and latching. This was acknowledged by the Maintenance Supervisor at the time of observation.		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/02/2012
PREFIX TAG RESCLATORY OR LSC IDENTIFYING INFORMATION) accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2–1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects two of five smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor on 08/02/12 at 1:20 p.m., the fire door set entering the 400 hall from the 300 hall nurses station did not latch into the frame when manually tested. The left hand door rubbed on the flooring preventing the door from closing and latching. This was acknowledged by the Maintenance Supervisor at the time of				STREET 500 N	WILLIAMS ST	
7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects two of five smoke compartments. Findings include: Based on an observation with the Maintenance Supervisor on 08/02/12 at 1:20 p.m., the fire door set entering the 400 hall from the 300 hall nurses station did not latch into the frame when manually tested. The left hand door rubbed on the flooring preventing the door from closing and latching. This was acknowledged by the Maintenance Supervisor at the time of	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
3.1-19(b)		accordance with 7.2.4.3.8 requiself closing or in accordance addition NFPA. Fire Doors and 2–1.4.1 requiremechanisms slovercome fire latch mechanisms ach operation. This affects two of compartments. Findings includes Based on an old Maintenance S. 08/02/12 at 1 door set enterifrom the 300 k did not latch in manually tested door rubbed opreventing the and latching. acknowledged Supervisor at tobservation.	ch 7.2.4 and ires fire doors to be automatic closing with 7.2.1.8. In 80, Standard for Windows at es all closing nall be adjusted to resistance of the em so positive fieved on each door is deficient practice five smoke. de: de: de: de: de: de: de: d			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/02/2012
			B. WINGSTREET /	ADDRESS, CITY, STATE, ZIP CODE	33.02.2012
NAME OF P	PROVIDER OR SUPPLIER			VILLIAMS ST	
		ING AND REHABILITATION	ANGOL	A, IN 46703	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
	*		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	01	COMPL	ETED
		155596	B. WIN			08/02/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		500 N V	VILLIAMS ST		
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION		ANGOL	A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0050 SS=F	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-F		d at unexpected times					
		nditions, at least quarterly					
		e staff is familiar with					
	•	s aware that drills are part					
		utine. Responsibility for					
	, ,	ducting drills is assigned t persons who are qualified					
		rship. Where drills are					
		en 9 PM and 6 AM a coded					
	announcement m	ay be used instead of					
	audible alarms.	19.7.1.2					
	Based on recor	d review and	K00	050	K 050		09/01/2012
	interview, the f	acility failed to			A make up fire drill for		
	ensure fire dril	ls were conducted			second 9-1-12 shift was conducted on 8-16-1	2	
	quarterly on ea	ich shift for 1 of the			See Attachment B.	۷.	
		ed quarters. This			A new calendar was complete	ed	
	·	ce could affect all			to indicate the month and wee	k	
	occupants.	ee eoura arreet arr			the		
	occupants.				firedrills are to occur. The Maintenance Director and		
	Finalinas inalis	la.			Administrator will retain copies		
	Findings includ	ie:			of this calendar. See Attachme		
		C.I. IIE:			С		
	Based on review				It is the responsibility of the M		
		l Report" with the			tenance Director tocarry out th	е	
	Maintenance Si	upervisor on			fire drills in a timely mannner.		
	08/02/12 at 1:	10 p.m., there was			The copy of the completed		
	no record of a	second shift fire			fire drills will be submitted to the	ne	
	drill for the sec	ond quarter of			Safety Committee for review.		
		n an interview with			The		
		ce Supervisor at the			Safety Committee will submitt		
		review, no other			fire drills to the Quality Assuration Committee overseen by the	ice	
		was available for			Administrator.		
	review to verify	uns uni was					
	conducted.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 01	(X3) DATE S COMPLE		
		155596	A. BUIL B. WING			08/02/2	2012
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION			VILLIAMS ST A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	3.1-19(b)						
	3.1-51(c)						
	Based on recor						
	•	acility failed to Is were conducted					
		ach shift for 1 of the					
	· ·	ed quarters. This					
		ice could affect all					
	occupants.						
	Findings includ	le:					
	Based on revie	w of the "Fire					
		l Report" with the					
	Maintenance S	•					
		:10 p.m., there was second shift fire					
		cond quarter of					
		n an interview with					
		ce Supervisor at the					
		review, no other					
	review to verify	was available for					
	conducted.	, tilis tillii was					
	2.1.10(1)						
	3.1-19(b) 3.1-51(c)						
	3.1 31(c)						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE COI	NSTRUCTION 01	(X3) DATE S COMPL	ETED
		155596	B. WING			08/02/	2012
	PROVIDER OR SUPPLIE	R SING AND REHABILITATION	50	00 N W	DDRESS, CITY, STATE, ZIP CODE /ILLIAMS ST A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ensure fire dri quarterly on e last 4 complet deficient pract occupants. Findings inclu Based on revie Evacuation Dr Maintenance S 08/02/12 at 1 no record of a drill for the se 2012. Based the Maintenar time of record documentatio	facility failed to Ils were conducted ach shift for 1 of the red quarters. This tice could affect all de: ew of the "Fire fill Report" with the					
	ensure fire dri quarterly on e	rd review and facility failed to Ils were conducted ach shift for 1 of the red quarters. This					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM	TE SURVEY MPLETED 02/2012
	PROVIDER OR SUPPLIER AND SKILLED NURSING AND REHABILITATION	500 N V	ADDRESS, CITY, STATE, ZIP (VILLIAMS ST .A, IN 46703	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	deficient practice could affect all occupants.				
	Findings include:				
	Based on review of the "Fire Evacuation Drill Report" with the Maintenance Supervisor on 08/02/12 at 1:10 p.m., there was no record of a second shift fire drill for the second quarter of 2012. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1–19(b) 3.1–51(c)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155596		(X2) M A. BUII B. WIN	LDING	O1	(X3) DATE (COMPL 08/02/	ETED	
	PROVIDER OR SUPPLIER	ING AND REHABILITATION		500 N V	ADDRESS, CITY, STATE, ZIP CODE VILLIAMS ST .A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0052 SS=F	installed, tested, a accordance with I Code and NFPA approved mainter complying with an NFPA 70 and 72. Based on obserinterview, the finstall 1 of 1 finaccordance with National Fire A 72, 1–5.4.6 recsignals to be lowhere it is likely NFPA 72, 1–5.4 alarms, supervitrouble signals and descriptive This deficient pall occupants. Findings include Based on an observation of the National Fire A 72, 1–5.4 alarms, supervitrouble signals and descriptive This deficient pall occupants. Findings include Based on an observation of the National Fire A 72, 1–5.4 alarms, supervitrouble signals and descriptive This deficient pall occupants.	m required for life safety is and maintained in NFPA 70 National Electrical 72. The system has an nance and testing program oplicable requirements of 9.6.1.4 Evation and facility failed to re alarm systems in the NFPA 72, the larm Code. NFPA quires trouble ocated in an area by to be heard. A.4 requires fire isory signals, and to be distinctive ely annunciated. Oractice could affect deservation with	K00	052	K 052 Upon discovery that the trouble alarm 9-1-12 could no longer be heard at the central nurses station, ASA, the fire systems vendor was notified a a request to move the alarm fit the current electrical room to to central nurses station was ma This relocation is scheduled be completed by 8-21-12 Monitoring of this alarm has be added to the Fire Door Alarm audit and will be montiored weekly for three months. If the alarm, the monitoring will drop one time a month during the monthly fire drill. The weekly audits will be submitted to the Safety Committee for review. Safety Committee will submitted audits to the Quality Assurance Committee overseen by the Administrator.	and rom he de. to een ere to	09/01/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155596	B. WIN	G		08/02/2012
NAME OF P	PROVIDER OR SUPPLIER	R		1	DDRESS, CITY, STATE, ZIP CODE	
	UD OKU LED NUDO	UNIO AND DELLABULITATION			VILLIAMS ST	
LAKELAI	ND SKILLED NURS	SING AND REHABILITATION		ANGOL	A, IN 46703	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHACI	DATE
		larm could not be				
	heard at the ce					
		vas confirmed by				
		upervisor at the				
	time of observa	ation.				
	3.1-19(b)					
	3 3(2)					
	Based on obse					
	interview, the facility failed to					
		re alarm systems in				
		h NFPA 72, the				
		larm Code. NFPA				
	72, 1–5.4.6 red					
	_	ocated in an area				
	where it is like	ly to be heard.				
		4.4 requires fire				
	·	isory signals, and				
	trouble signals	to be distinctive				
	I = = = = = = = = = = = = = = = = = = =	ely annunciated.				
	·	oractice could affect				
	all occupants.					
	Findings includ	de:				
	Based on an ob					
	Maintenance Si	•				
		:30 p.m., when the				
		er component was				
	placed in troub	ole from phone line				
	failure a local t	rouble alarm was				
	initiated. The	trouble alarm was				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE S COMPL		
		155596	A. BUII B. WIN	LDING G		08/02/	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION			VILLIAMS ST A, IN 46703		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤΕ	COMPLETION DATE
	located in an e	lectrical room down					
		ne central nurses					
	heard at the ce	arm could not be					
		vas confirmed by					
		upervisor at the					
	time of observ	ation.					
	3.1-19(b)						
	Based on obse	rvation and facility failed to					
		re alarm systems in					
		h NFPA 72, the					
		larm Code. NFPA					
	72, 1–5.4.6 red						
	where it is like	ocated in an area					
		4.4 requires fire					
	•	isory signals, and					
	_	to be distinctive					
		ely annunciated.					
	all occupants.	oractice could affect					
	an occupants.						
	Findings includ	le:					
	Based on an ob	oservation with					
	Maintenance S	= -					
		:30 p.m., when the					
		er component was ble from phone line					
	piaceu iii tiout	ne iroin phone ille					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	(X2) MU A. BUIL B. WINC	DING	01	(X3) DATE (COMPL 08/02/	ETED
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		500 N W	DDRESS, CITY, STATE, ZIP CODE /ILLIAMS ST A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	initiated. The located in an ethe hall from the station. The all heard at the cestation. This w	vas confirmed by upervisor at the					
	install 1 of 1 fi accordance with National Fire A 72, 1–5.4.6 rec signals to be low where it is like NFPA 72, 1–5.4 alarms, superve trouble signals and descriptive	facility failed to re alarm systems in th NFPA 72, the larm Code. NFPA quires trouble ocated in an area					
	Findings includ	de:					
	Based on an ob Maintenance So 08/02/12 at 2						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/02/2012
	PROVIDER OR SUPPLIEI	R SING AND REHABILITATION	500 N \	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST _A, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	placed in trouble failure a local failure a local failure a local failure and the hall from the station. The analystation. This wastation. This wastation.	vas confirmed by upervisor at the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	03	COMPLETED
		155596	B. WING		08/02/2012
	D O V V D D D O O O O O O O O O O O O O	<u> </u>	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			WILLIAMS ST	
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION		LA, IN 46703	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
	A Life Safety Co	ode Recertification,	K0000	This Plan of Correction is the	
	State Licensure			center's	
		k-thru Survey were		credible allegation of complian	nce.
		he Indiana State		Preparation and /or execution	of
	Department of			this	OI
	-			plan of correction does not	
	accordance wit	h 42 CFR 483.70(a).		constitute admission or	
	Survey Date: 0	18 /02 /12		agreement by the	_
	Survey Date. 0	18/02/12		provider of the truth of the fac	ts
	e 115 N 1	000474		al- leged or conclusions set forth	in
	Facility Numbe			the	""
	Provider Numb			statement of deficienceis. The	e
	AIM Number:	100290510		plan of correction is prepared	
				and/or executed	
	Surveyor: Amy	Kelley, Life Safety		solely because it is required b	У
	Code Specialist	ī.		the provisions of federal and state	<u> </u>
				law.	, l
	At this Life Safe	ety Code survey,			
	Lakeland Skille				
		was found not in			
		h Requirements for			
	Participation in	·			
	Medicare/Medi				
	·				
	Subpart 483.70	•			
		he 2000 edition of			
	the National Fi				
		FPA) 101, Life Safety			
	` ′	l 410 IAC 16.2. The			
	new 2012 addi	tion of the 400 hall			
	was surveyed v	vith Chapter 18,			
	New Health Ca	re Occupancies.			
	This one story	facility was			

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 08/02/2012
	PROVIDER OR SUPPLIE	L R SING AND REHABILITATION	STREET 500 N	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST LA, IN 46703	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	construction a sprinklered. Talarm system of detection in the areas open to resident rooms and 400 hall he smoke detector rooms on the coperated smoof facility has a compliance withis survey. The facility was compliance with regard to sprinklered. The detached shed services include supplies that we compliance with a compliance with the facility was compliance with the facility was compliance with a forementioned.	The facility has a fire with smoke he corridors and the corridors. The son the 300 hall ad hard wired fors. The resident 200 hall had battery for detectors. The apacity of 75 and for 74 at the time of for coverage and for coverage. The residents have the facility had a providing facility ling maintenance for sound not in the the found not in the the found not in the facility had a sound not in the found not in the found not in the found not in the found not in the facility had a sound not in the found not in the found not in the found not in the found not in the facility had a sound not in the found not in the found not in the found not in the found not in the facility had a sound not in the found not in the facility had a sound not in the found not in the facility had a sound not in th			

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Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	03	COMPL	ETED
		155596	B. WIN		-	08/02/	2012
		l .			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R		500 N V	VILLIAMS ST		
	ND SKILLED NURS	BING AND REHABILITATION			A, IN 46703		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	A Life Safety C	ode Recertification,					
	State Licensure	e and Quality					
	Assurance Walk-thru Survey were conducted by the Indiana State						
	Department of						
	-	th 42 CFR 483.70(a).					
	accordance Wit	cc					
	Survey Date: (08/02/12					
	Eacility Numbe	or: 000474					
Facility Number: 000474 Provider Number: 155596							
	AIM Number:	100290510					
	Surveyor: Amy	y Kelley, Life Safety					
	Code Specialis	•					
	Code Specialis						
	At this Life Saf	ety Code survey,					
	Lakeland Skille	ed Nursing and					
	Rehabilitation	was found not in					
		th Requirements for					
	Participation in						
	Medicare/Med						
	•	0(a), Life Safety					
	l .	• • • •					
		the 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
		d 410 IAC 16.2. The					
		ition of the 400 hall					
	was surveyed with Chapter 18,						
	New Health Ca	re Occupancies.					
	This are set	fa ailia					
	This one story	=					
	determined to	be of Type V (111)					

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Event ID: 2SVX21

Facility ID: 000474

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596			ULTIPLE CO LDING	NSTRUCTION 03	(X3) DATE S COMPLI 08/02/2	ETED
		133390	B. WIN			00/02/	2012
NAME OF F	PROVIDER OR SUPPLIEI	3			DDRESS, CITY, STATE, ZIP CODE		
LAKELA	ND SKILLED NURS	SING AND REHABILITATION			VILLIAMS ST A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	construction a	•					
	sprinklered. The facility has a fire						
	alarm system v	with smoke					
	detection in th	e corridors and					
	areas open to	the corridors. The					
	resident room:	s on the 300 hall					
	and 400 hall h	ad hard wired					
	smoke detecto	rs. The resident					
	rooms on the	200 hall had battery					
	operated smol	ce detectors. The					
facility has a capacity of 75 and		apacity of 75 and					
	had a census o	of 74 at the time of					
	this survey.						
	,						
	The facility wa	s found in					
	compliance wi						
	l '	ikler coverage and					
	smoke detecto						
		e the residents have					
	customary acc						
	_ =	he facility had a					
		providing facility					
	services includ	ling maintenance					
	supplies that v	vas not sprinklered.					
	The facility wa	s found not in					
	compliance wi						
	aforementione						
		as evidenced by the					
	following:						

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 03	(X3) DATE SURV	D	
		155596	B. WING		08/02/201	2
	PROVIDER OR SUPPLIER	ING AND REHABILITATION	500 N	ET ADDRESS, CITY, STATE, ZIP CODE N WILLIAMS ST OLA, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) OMPLETION DATE
K0021 SS=E	enclosure, horizo hazardous area e by devices arrang all such doors by facility upon activ a) the required m b) local smoke de smoke passing the required smoke de smoke passing the required smoke de installed. 18.2. Based on obserview, the fensure 1 of 5 he door sets was led device which we close automatic activation of the This deficient per two of five smooth findings included assed on observity and the smooth findings included asset of the smooth findings i	cit passageway, stairway intal exit, smoke barrier or enclosure is held open only ged to automatically close zone or throughout the ation of: anual fire alarm system; etectors designed to detect brough the opening or a etection system; and esprinkler system, if 2.2.6 7.2.1.8.2 rivation and facility failed to encrizontal exit fire eneld open only by a rould allow it to cally upon the fire alarm system. Foractice could affect toke compartments. de: rivation with the	K0021	K021 Upon failure of the ho open magnetic 9-1-12 devi the fire doors entering 400 from 300 hall, Symplex, the system vendor was called a asked to fix this issue. It wi corrected on 8-20-12These will be tested one time per vito make sure the system is working properly and will be tested each time Symplex is working on any part of the system, prior to them exiting premise. If no issues are presented in three months the audit will decrease to testing doors one time per month of the monthly fire drill. See Attachment A, Fire Door At Sheet. The audit sheet will be turned into the Safety Common a monthly basis for revier The Safety Committee will sthe audits to the Quality Assurance Committee overse	ces on nall fire nd lbe doors week lb lbe doors week lb lbe doors week lb	9/01/2012

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Event ID: 2SVX21

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 08/02/2012
	PROVIDER OR SUPPLIE	R SING AND REHABILITATION	500 N \	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST _A, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Maintenan time of observ	ce Supervisor at the ration.		by the Administrator.	
	3.1-19(b)				
	ensure 1 of 5 door sets was device which we close automation of the This deficient	facility failed to horizontal exit fire held open only by a vould allow it to ically upon ne fire alarm system. practice could affect oke compartments.			
	Maintenance S 08/02/12 at 2 open magnetic doors entering the 300 hall no release upon a alarm. This wa	:40 p.m., the hold c devices on the fire g the 400 hall from urses station did not activation of the fire as acknowledged by ce Supervisor at the			
	Based on obse	rvation and facility failed to horizontal exit fire			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	03	COMPL	ETED
		155596	B. WIN			08/02/	/2012
NAME OF F	DOLUDED OD GUDDI IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			500 N V	VILLIAMS ST		
		SING AND REHABILITATION		<u> </u>	A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
1710		held open only by a		1110			DATE
		vould allow it to					
	close automati						
		ne fire alarm system.					
		practice could affect					
	two or five sme	oke compartments.					
	Findings includ	de:					
	Based on obse	rvation with the					
	Maintenance Supervisor on						
		:40 p.m., the hold					
		devices on the fire					
		the 400 hall from					
	_	urses station did not					
		ctivation of the fire					
	-	as acknowledged by					
		ce Supervisor at the					
	time of observ	·					
	time of objetv	acion.					
	3.1-19(b)						
	Based on obse	rvation and					
		facility failed to					
		norizontal exit fire					
		held open only by a					
		vould allow it to					
	close automati						
		ne fire alarm system.					
		· ·					
	This deficient practice could affect two of five smoke compartments.						
	1770 01 1170 31110	one comparements.					
	Findings includ	de:					
			ı				I

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED
		155596	B. WING		08/02/2012
	PROVIDER OR SUPPLIE	R SING AND REHABILITATION	500 N \	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST _A, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance S 08/02/12 at 2 open magnetic doors entering the 300 hall n release upon a alarm. This w	2:40 p.m., the hold c devices on the fire g the 400 hall from urses station did not activation of the fire as acknowledged by ace Supervisor at the			

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Event ID: 2SVX21

Facility ID: 000474

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596 NAME OF PROVIDER OR SUPPLIER		(X2) MI A. BUII B. WIN	LDING G STREET A	ONSTRUCTION 03 ADDRESS, CITY, STATE, ZIP CODE VILLIAMS ST	(X3) DATE S COMPL 08/02/	ETED	
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION			A, IN 46703		
(X4) ID PREFIX TAG K0044 SS=E	(EACH DEFICIEN REGULATORY OR NFPA 101 LIFE SAFETY CO			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	with 7.2.4. 18.2 Based on observiterview, the fensure 1 of 5 farranged to au and latch. LSC horizontal exit accordance with 7.2.4.3.8 requiself closing or in accordance waddition NFPA. Fire Doors and 2–1.4.1 requires mechanisms shovercome fire relatch mechanisms shovercome fire relatching is achieved accordance. This affects two of faccompartments. Findings includes Based on an observation. This affects two of faccompartments. Findings includes Based on an observation of faccompartments. Findings includes Based on an observation of faccompartments of the faccompartme	rvation and facility failed to lire door sets was stomatically close 18.2.2.5 requires to be in h 7.2.4 and res fire doors to be automatic closing with 7.2.1.8. In 80, Standard for Windows at less all closing hall be adjusted to resistance of the lire m so positive leved on each door is deficient practice five smoke less less all closing hall be adjusted to resistance of the less all closing hall be adjusted to resistance of the less deficient practice five smoke less all closing hall be actionally and the less deficient practice five smoke less deficient with the	K00	44	K 044 Upon the failure of the f door set 9-1-12 entering 400 I from 300 Hall, to latch into the frame, the superintend- ant for the building project immediate ad- justed the door so that it would close properly and latch into the frame. This was completed on 8- 2-12. In order make sure this door set is properly working, the door set be tested weekly. See Attachment A, Fire Door Audit. If the weekly test does not produce issues in three months, then the weekly tests will decrease to out time monthly during the month fire drill. The weekly audit shew will be reviewed by the Safety Committee on a monthly basis. The Safety Committee will subthe audits To the Quality Assurance Committee overse by the Adminis- trator.	Hall Iy Ito will e any ne ne ly et	09/01/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596			(X2) MU A. BUIL		NSTRUCTION 03	(X3) DATE S COMPLE 08/02/2	TED
		155596	B. WIN			08/02/2	2012
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
LAKELAN	ND SKILLED NURS	SING AND REHABILITATION			A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
	door rubbed o						
		door from closing					
	and latching. ⁻	This was					
	_	by the Maintenance					
	Supervisor at t	he time of					
	observation.						
	3.1-19(b)						
	Based on obse	rvation and					
	interview, the f	facility failed to					
	ensure 1 of 5 f	ire door sets was					
	_	tomatically close					
		18.2.2.5 requires					
	horizontal exit						
		ires fire doors to be					
	· ·	automatic closing					
		with 7.2.1.8. In					
	addition NFPA	80, Standard for					
	Fire Doors and						
	2–1.4.1 require	_					
		nall be adjusted to resistance of the					
	latch mechanis						
		ieved on each door					
		s deficient practice					
	affects two of f	five smoke					
	compartments						
	Findings includ	de:					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155596	LDING	NSTRUCTION 03	(X3) DATE COMPL 08/02/	ETED
NAME OF I	PROVIDER OR SUPPLIEF			DDRESS, CITY, STATE, ZIP CODE	•	
LAKELA	ND SKILLED NURS	ING AND REHABILITATION		A, IN 46703		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Maintenance Sci 08/02/12 at 1 door set entering from the 300 hidd not latch in manually tested door rubbed or preventing the and latching. acknowledged Supervisor at tobservation. 3.1–19(b) Based on obseinterview, the fensure 1 of 5 fearranged to au and latch. LSC horizontal exitaccordance with 7.2.4.3.8 requiself closing or in accordance addition NFPA Fire Doors and 2–1.4.1 requiremechanisms slipping the set of	response to the fire and the 400 hall hall nurses station and the flooring door from closing this was by the Maintenance he time of revation and facility failed to fire door sets was tomatically close 18.2.2.5 requires to be in the 7.2.4 and fires fire doors to be automatic closing with 7.2.1.8. In 80, Standard for Windows at the sall closing hall be adjusted to resistance of the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 03	ľ ′	ATE SURVEY MPLETED	
		155596	A. BUILDING B. WING			/02/2012
NAME OF	DD OVADED OD GUDDI IE	n		ADDRESS, CITY, STATE, ZIF	CODE	
	PROVIDER OR SUPPLIE			VILLIAMS ST		
LAKELA	ND SKILLED NURS	SING AND REHABILITATION	ANGOL	.A, IN 46703		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5) COMPLETION
TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	DATE
	latching is ach	ieved on each door				
	operation. Th	is deficient practice				
	affects two of five smoke					
	compartments	i.				
	Findings inclu	de:				
	Based on an o	bservation with the				
	Maintenance S					
		:20 p.m., the fire				
	door set enter	ing the 400 hall				
	from the 300	hall nurses station				
	did not latch i	nto the frame when				
		ed. The left hand				
	door rubbed o					
	1 '	door from closing				
	and latching.					
	Supervisor at t	by the Maintenance				
	observation.	the time of				
	observation.					
	3.1-19(b)					
	Based on obse	rvation and				
	interview, the	facility failed to				
	ensure 1 of 5	fire door sets was				
	arranged to au	itomatically close				
		18.2.2.5 requires				
	horizontal exi					
	accordance wi					
	I	ires fire doors to be				
	self closing or	automatic closing				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 08/02/2012	
NAME OF PROVIDER OR SUPPLIER LAKELAND SKILLED NURSING AND REHABILITATION			STREET A	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST LA, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	addition NFPA Fire Doors and 2-1.4.1 requir mechanisms soovercome fire latch mechanis latching is ach operation. The affects two of compartments Findings includ Based on an ole Maintenance Soos/02/12 at 1 door set enter from the 300 he did not latch in manually tested door rubbed of preventing the and latching.	es all closing hall be adjusted to resistance of the sm so positive ieved on each door is deficient practice five smoke . de: de: de: 20 p.m., the fire ing the 400 hall hall nurses station into the frame when d. The left hand in the flooring door from closing This was by the Maintenance			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	03	COMPLETED	
		155596	B. WING		08/02/2012
NAME OF F	DOLUBER OF GURNIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIE	R	500 N	WILLIAMS ST	
LAKELA		SING AND REHABILITATION	ANGO	LA, IN 46703	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0050 SS=F	NFPA 101	ODE STANDARD			
33-6		d at unexpected times			
		nditions, at least quarterly			
	on each shift. Th	ne staff is familiar with			
	•	is aware that drills are part			
		utine. Responsibility for			
		nducting drills is assigned nt persons who are qualified			
		ership. Where drills are			
		een 9 PM and 6 AM a coded			
		nay be used instead of			
	audible alarms.	. •	170050		00/01/0010
	Based on reco		K0050	K 050 A make up fire drill for	09/01/2012
	•	facility failed to		second 9-1-12	
	ensure fire dri	lls were conducted		shift was conducted on 8-16-1	2.
	quarterly on e	ach shift for 1 of the		See Attachment B.	
	last 4 complet	ed quarters. This		A new calendar was complete	
	deficient pract	ice could affect all		to indicate the month and wee	K
	occupants.			firedrills are to occur.	
				The Maintenance Director and	ı
	Findings inclu	de:		Administrator will retain copies	
				of this calendar. See Attachmo	ent
	Based on revie	w of the "Fire		C It is the responsibility of the M	lain-
		ll Report" with the		tenance Director tocarry out th	
	Maintenance S	•		fire	
		:10 p.m., there was		drills in a timely mannner.	
		second shift fire		The copy of the completed fire drills will be submitted to the	
		cond guarter of		Safety Committee for review.	IC
		•		The	
		on an interview with		Safety Committee will submitt	
		ce Supervisor at the		fire drills to the Quality Assura	nce
		review, no other		Committee overseen by the Administrator.	
		n was available for		Auministrator.	
	review to verif	y this drill was			
	conducted.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	03	COMPL	
		155596	B. WIN			08/02/	2012
NAME OF P	PROVIDER OR SUPPLIEF	. {	_	STREET A	DDRESS, CITY, STATE, ZIP CODE	_	
					VILLIAMS ST		
LAKELAN	ND SKILLED NURS	SING AND REHABILITATION		ANGOL	A, IN 46703		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	3.1-19(b)						
	3.1-51(c)						
	Based on recor	rd raview and					
		facility failed to					
		lls were conducted					
		ach shift for 1 of the					
	'	ed quarters. This					
	•	•					
	-	ice could affect all					
	occupants.						
	Findings includ	de:					
	Maintenance S 08/02/12 at 1 no record of a drill for the sec 2012. Based of the Maintenance time of record	Il Report" with the upervisor on:10 p.m., there was second shift fire cond quarter of on an interview with ce Supervisor at the review, no other n was available for					
	Based on recor interview, the f ensure fire dril	rd review and facility failed to Ils were conducted ach shift for 1 of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	03	COMPLETED
		155596	B. WING		08/02/2012
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
IAKFIAN	ND SKILLED NUR:	SING AND REHABILITATION		WILLIAMS ST LA, IN 46703	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	T	(V5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	last 4 complet	ted quarters. This			
	deficient prac	tice could affect all			
	occupants.				
	Findings inclu	de:			
	Based on revie				
		ill Report" with the			
	Maintenance S	•			
		1:10 p.m., there was			
		second shift fire			
		econd quarter of			
		on an interview with			
		nce Supervisor at the			
		l review, no other			
		n was available for			
		fy this drill was			
	conducted.				
	2.1.10/b)				
	3.1-19(b)				
	3.1-51(c)				
	Based on reco	ord review and			
	interview, the	facility failed to			
		ills were conducted			
	quarterly on e	ach shift for 1 of the			
	I	ted quarters. This			
	deficient prac	tice could affect all			
	occupants.				
	Findings inclu	de:			
	Based on revie	ew of the "Fire			
	I		1		

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Event ID: 2SVX21

Facility ID: 000474

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 08/02/2012	
	PROVIDER OR SUPPLIE	R SING AND REHABILITATION	500 N	ADDRESS, CITY, STATE, ZIP CODE WILLIAMS ST LA, IN 46703	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance S 08/02/12 at 1 no record of a drill for the se 2012. Based of the Maintenan time of record documentatio	ill Report" with the supervisor on :10 p.m., there was second shift fire cond quarter of on an interview with ce Supervisor at the review, no other n was available for ty this drill was			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 03		COMPLETED	
	155596		B. WING		08/02/2012	
NAME OF D	ROVIDER OR SUPPLIER		STREE	Γ ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		500 N	WILLIAMS ST		
	ND SKILLED NURS	ING AND REHABILITATION	ANGO	DLA, IN 46703		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG K0052	NFPA 101	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE	
SS=F	LIFE SAFETY CO	ODE STANDARD				
00-1		em required for life safety is				
		and maintained in				
		NFPA 70 National Electrical				
		72. The system has an				
		nance and testing program oplicable requirements of				
	NFPA 70 and 72.					
	Based on obse	rvation and	K0052	K 052 Upon discovery that the		
	interview, the f	facility failed to		trouble alarm 9-1-12 could no longer be heard at the central		
	install 1 of 1 fi	re alarm systems in		nurses station, ASA, the fire		
	accordance wit	h NFPA 72, the		systems vendor was notified a	ind	
	National Fire A	larm Code. NFPA		a request to move the alarm fr		
	72, 1-5.4.6 red	quires trouble		the current electrical room to t central nurses station was ma	-	
	signals to be lo	ocated in an area		This reloca- tion is scheduled		
	where it is like	ly to be heard.		be completed by 8-21-12		
	NFPA 72, 1-5.4	1.4 requires fire		Monitoring of this alarm has be	een	
	alarms, superv	isory signals, and		added to the Fire Door Alarm		
	=	to be distinctive		audit and will be montiored weekly for three months. If the	ere	
	_	ely annunciated.		are no further issues with the		
	-	oractice could affect		alarm, the monitoring will drop	to	
	all occupants.			one time a month dur- ing the		
				monthly fire drill. The weekly audits will be submitted to the		
	Findings includ	le·		Safety Committee for review.	The	
	a.iiga iiicide	· - ·		Safety Committee will submitt	the	
	Based on an ob	servation with		audits to the Quality Assurance	e	
	Maintenance Si			Committee overseen by the Admin- istrator.		
		•		Aumin- istrator.		
		:30 p.m., when the				
		er component was				
	_ =	ole from phone line				
		rouble alarm was				
		trouble alarm was				
		lectrical room down				
	the hall from th	he central nurses				

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Event ID: 2SVX21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPI		
			LDING	03		/2012	
		100000	B. WIN		DDDECC CITY CTATE 7ID COD		72012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP COD VILLIAMS ST	Ē.	
LAKELAND SKILLED NURSING AND REHABILITATION					A, IN 46703		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		larm could not be					
	heard at the ce						
		vas confirmed by					
		upervisor at the					
	time of observ	ation.					
	3.1-19(b)						
	Based on obse	rvation and					
		facility failed to					
	•	re alarm systems in					
		th NFPA 72, the					
		larm Code. NFPA					
	72, 1–5.4.6 red						
		ocated in an area					
	where it is like						
		4.4 requires fire					
	•	isory signals, and					
	-	to be distinctive					
	_	ely annunciated.					
		oractice could affect					
	all occupants.						
	Findings includ	de:					
	Based on an ob	oservation with					
	Maintenance S	upervisor on					
	08/02/12 at 2	:30 p.m., when the					
	automatic diale	er component was					
	placed in troub	ole from phone line					
	failure a local t	rouble alarm was					
	initiated. The	trouble alarm was					
	located in an e	lectrical room down					
	the hall from tl	he central nurses					

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Event ID: 2SVX21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED	
ANDILAN	or condition	155596	A. BUILDING B. WING		08/02/2012
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	I
				WILLIAMS ST	
		SING AND REHABILITATION	ANGO	LA, IN 46703	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	station. The a	larm could not be			
	heard at the ce	entral nurses			
	station. This v	vas confirmed by			
	Maintenance S	upervisor at the			
	time of observ	ation.			
	3.1-19(b)				
	Based on obse	rvation and			
		facility failed to			
	install 1 of 1 fi	re alarm systems in			
	accordance wit	h NFPA 72, the			
	National Fire A	larm Code. NFPA			
	72, 1-5.4.6 red	quires trouble			
	signals to be lo	ocated in an area			
	where it is like	ly to be heard.			
	NFPA 72, 1-5.4	4.4 requires fire			
	alarms, superv	isory signals, and			
	trouble signals	to be distinctive			
	and descriptive	ely annunciated.			
		oractice could affect			
	all occupants.				
	Findings includ	de:			
	Based on an ol	oservation with			
	Maintenance S				
		:30 p.m., when the			
		er component was			
		ole from phone line			
	_ ·	rouble alarm was			
	initiated. The	trouble alarm was			
	located in an e	lectrical room down			
	the hall from t	he central nurses			

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Event ID: 2SVX21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155596		A. BUI	LDING	03	COMPLETED 08/02/2012	
100000			B. WIN		PRESIDENCE OF THE CORP.	00/02/2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE VILLIAMS ST	
LAKELAN	ND SKILLED NURS	ING AND REHABILITATION			A, IN 46703	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
1710		larm could not be		1710	·	DATE
	heard at the ce					
		vas confirmed by				
		upervisor at the				
	time of observa	=				
	tille of observe	ation.				
	3.1-19(b)					
	Based on obse	rvation and				
	interview, the f	facility failed to				
	•	re alarm systems in				
		h NFPA 72, the				
	National Fire Alarm Code. NFPA					
	72, 1–5.4.6 red	guires trouble				
		cated in an area				
	where it is like					
		4.4 requires fire				
		isory signals, and				
	-	to be distinctive				
	_	ely annunciated.				
	This deficient	oractice could affect				
	all occupants.					
	Findings includ	de:				
	Based on an ob					
	Maintenance Si	upervisor on				
	08/02/12 at 2	:30 p.m., when the				
	automatic diale	er component was				
	l -	ole from phone line				
	failure a local t	rouble alarm was				
	initiated. The	trouble alarm was				
	located in an e	lectrical room down				
	the hall from t	he central nurses				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155596	(X2) MULTIPLE CO A. BUILDING B. WING	03	— COM	TE SURVEY MPLETED 02/2012
	PROVIDER OR SUPPLIER ND SKILLED NURSING AND REHABILITATION	500 N V	ADDRESS, CITY, STATE, ZIP WILLIAMS ST .A, IN 46703	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	station. The alarm could not be heard at the central nurses station. This was confirmed by Maintenance Supervisor at the time of observation. 3.1–19(b)				

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